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Article

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Abstract
This article suggests the merits of conceptualizing incarceration as including institutionalization in a wide variety of enclosed settings, including prisons, jails, institutions for the intellectually disabled, treatment centers, and psychiatric hospitals. Such formulations conceptualize incarceration as a continuum and a multi-faceted phenomenon. This article will highlight the importance of moving beyond analogies between criminalization, institutionalization and psychiatrization to discuss the intersection of these phenomena, by highlighting several social science perspectives that have integrated these spheres already; taking up an analysis of the political economy of incarceration; and re-examining the reality of prisoners with disabilities in the growing prison machine. Lastly, I propose a re-examination of the forces of trans-incarceration, the move from one carceral edifice such as a psychiatric hospital to another such as a jail. I will demonstrate the ways in which engaging in such intersectional analysis changes the lens from which disability and incarceration are conceptualized and analyzed.

Keywords
disability, intersectionality, mental health, political economy, prisons, critical theory

Introduction

There has been much recent interest among social scientists in the issue of 'mass incarceration' (see for instance Garland, 2001; Gilmore, 2006; Gottschalk, 2006; Pager, 2009; Sim, 2009; Wacquant, 2009; Western, 2006). For the most part, this surge in scholarship, analysis and calls for reform does not include analysis of disability and ableism. One area of sociological analysis that seems to encompass incarceration and disability is in accounts that depict imprisonment of those with psychiatric and developmental disabilities as related to a perceived failure of the

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policy of deinstitutionalization (see Crissey and Rosen, 1986; Dear and Wolch, 1987; Isaac and Armat, 1990; Johnson, 1990; Torrey, 1996; Wacquant, 2009), which will be discussed and critiqued later in relation to forces of trans-incarceration. Another exception to this lacuna is the work of Bernard Harcourt (2006, 2011), which connects research on hospitalization in psychiatric hospitals to research on the growth of the prison machine in the USA.

On the other hand, the vast literature in the growing field of disability studies has paid very little attention to the imprisonment of people with disabilities, especially in North America. One notable exception is work on institutionalization and hospitalization of people with a variety of impairments, written from sociological, historical and phenomenological perspectives (for example Ferguson, 1994; Johnson, 1998; Reaume, 2000). However, very little attention has been given to other forms of incarceration in relation to disability – especially to the increased reliance of the state on prisons and jails, and there is a lack of connection between disability studies literature and the various sociological analyses of the prison-industrial complex, mentioned above.

Although disability studies is a diverse and interdisciplinary field, it seems that it often has a sociological orientation interested in the lived experiences of those with disabilities. Yet there is little research about the lived experience of those incarcerated in a variety of settings including prisons and jails, and analysis of the forces of imprisonment from a disability perspective. Sociology, at least in one of its formulations, should be concerned with finding the people where they are located and explaining their circumstances in ways that they might not be able to see from their location, or garnering people's lived knowledge about their location, which may be unfamiliar to outsiders. Both of these interpretations could be connected back to C. Wright Mills's formulation of the sociological imagination as the ability and the desire to connect one's 'personal trouble' to 'public issues' (Mills, 1959). If sociology and disability studies are indeed concerned with both the lived experience of disabled people and the 'matrix of domination' (Collins, 2000) that sustain ableism, then I propose they need to pay attention to processes of incarceration and imprisonment as major 'public issues' taking place within the global North and South (albeit in different ways). I thus call for a tighter connection between the sociology of disability, or the study of the ontology and phenomenological experiences of disabled people and analysis of ableism, and the critical sociological study of incarceration.

This article will offer several connecting points through which disability and incarceration could be studied. The first is a brief overview of several social science perspectives that have integrated these spheres already. The second takes up an analysis of the political economy of incarceration, encompassing prisons and jails but also institutions and nursing homes. The third connecting point lies in the intersection of incarceration and disability – the reality of prisoners with disabilities in the growing prison machine, especially in North America. Lastly, I propose a re-examination of the forces of trans-incarceration, or the move from one carceral edifice such as a psychiatric hospital to another such as a jail. This analysis will pave the way to a broader and deeper understanding of what incarceration entails, in its varied forms. What underpins all these arguments is the idea that incarceration should be perceived as a continuum, ranging from prisons and jails to institutions for the intellectually disabled,[1] and psychiatric hospitals. I therefore advocate an interpretation of incarceration that yields an analysis which is both nuanced and intersectional from its outset.

Broadening the Scope of Incarceration

The need to combine the discussion on current levels of imprisonment with discussion and data about institutionalization, hospitalization and disablement is imperative for practical, empirical

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and theoretical reasons. The most pressing is the need to expand on notions of what comes to be classified as 'incarceration'. This article suggests the merits of conceptualizing incarceration as including institutionalization in a wide variety of enclosed settings, including prisons, jails, detention centers, institutions for the intellectually disabled, treatment centers, and psychiatric hospitals. Such formulations conceptualize incarceration as a continuum and a multi-faceted phenomenon. This analysis is especially pressing because of the immense growth of the prison machine in the USA.

For the first time in US history, in 2008, more than one in 100 American adults was behind bars. In 2009 the adult incarcerated population in prisons and jails in the USA had reached 2,284,900 according to the Bureau of Justice Statistics (BJS, 2010). The USA incarcerates a greater share of its population, 737 per 100,000 residents, than any other country on the planet (Pew Center, 2008). Another whopping 5,018,900 people are under 'community corrections,' which include parole and probation (BJS, 2010). Race, gender and disability play a significant role in incarceration rates. In 2006, Caucasians/whites were imprisoned at a rate of 409 per 100,000 residents; Latinos at 1038 per 100,000 and African-Americans at 2468 per 100,000. The rate for women was 134 per 100,000 residents and for men, 1384 per 100,000. In 2005 more than half of all prison and jail inmates were reported as having a mental health problem. Nearly a quarter of both state prisoners and jail inmates who had a mental health problem, compared to a fifth of those without, had served three or more prior incarcerations (Prison Policy Initiative, 2008). The number of carceral edifices in the USA had grown as well. From 2000 to 2005, the number of state and federal correctional facilities increased by 9 percent, from 1668 to 1821 (BJS, 2008).

In contrast to the constant expansion of prisons, deinstitutionalization and institution closure have been a major policy trend in most US states in the past few decades. Deinstitutionalization of people who were labeled as 'mentally ill' began in the 1950s. The deinstitutionalization in the field of 'mental retardation' gained prominence in the 1970s, although this of course varied by state. The population of people with intellectual disabilities living in large public institutions peaked at 194,650 in 1967. By 2004, this number had declined to 41,653 (Prouty et al., 2005). The trend in deinstitutionalization for people with intellectual disabilities was accompanied by institutional closures across most states. By 2009, the District of Columbia, Alaska, Hawaii, Maine, New Hampshire, New Mexico, Rhode Island, Vermont, and West Virginia had closed all of their public institutions for people with developmental disabilities (Lakin et al., 2010). In contrast, 13 states have not closed any such public institutions (Braddock, 2002).

An accompanying shift occurred in the field of mental health with the establishment of the community mental health centers in the 1960s and the closure of large state mental hospitals in most major cities. In 1955, the state mental health population was 559,000, nearly as large on a per capita basis as the prison population today. By 2000, it had fallen to below 100,000, a drop of more than 90 percent (Gottschalk, 2010; Harcourt, 2011). Deinstitutionalization in the field of developmental disabilities occurred about 12 years after the deinstitutionalization of public mental hospitals, and the rate of reduction of use of these facilities was also significantly different between the two processes. In the first 10 years of deinstitutionalization for traditional institutions for those labeled as 'mentally retarded', the institutionalized population was reduced by 30 percent and then averaged about 11 percent a year during the 1970s. At its height, between 1955 and 1965, the deinstitutionalization in psychiatric hospitals reduced the populations by 15 percent only (Lerman, 1985).

Over the years, some of the figures given for deinstitutionalization of public institutions have been misleading, as significant proportions of people were transferred to other types of institutions including nursing homes. In 2009, for instance, 12,475 people with developmental disabilities

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lived in state operated community residential settings with 15 or fewer residents. In addition, between 1977 and 2009, the total number of residential settings in which people with developmental disabilities received residential services grew from 11,008 to an estimated 173,042, an increase of 1500 percent (Lakin et al., 2010). Because most of these newer settings are much smaller than the massive institutions of previous decades, they are not typically counted as 'institutional' placements, but due to their daily routines and other aspects of life in these settings, many people with disabilities, family members, and advocates consider them to be mini-institutions within the community (Center on Human Policy, 2004).

From this critical intersection, it may not be surprising to also learn that physically, many institutions for those labeled as psychiatrically or developmentally disabled that closed down during the 1980s actually re-opened a few years later as prisons. Alabama turned three-quarters of its closed institutions (which closed in 2003) into correctional facilities (the fourth quarter's use is undetermined). Illinois closed seven institutions, two of which became correctional facilities and a third a women's prison. New York State had the absolute largest number of institutions in the USA, seventeen of which closed between 1970 and 2010. Most of them were left as is, with future usage undetermined, but at least two became correctional facilities (Braddock et al., 2008). These figures, although not comprehensive by any means, serve to highlight the cyclical nature of social control and the persistent nature of incarceration as a strategy to categorize and keep out 'undesirable' populations.

I want to be clear here, that proposing a more thoroughly 'intersectional' history is distinct from proposing that ableism and racism, or asylums and prisons, are the same. It is the similarities and the distinctions that are important to attend to, in terms of rationalizations, in terms of practices associated with them, and also in terms of the effects on the people who are incarcerated in diverse sites of confinement. For example, the criminal justice system seems to offer certain protections to the accused and the prisoner, such as due process during the trial and sentencing procedures, a sentence of a specified duration. However, medical institutions allow the compulsory admittance of patients against their will based only on a medical diagnosis, an indefinite time of commitment, and 'treatments' that are both painful and harmful, such as extended periods of isolation, physical restraints, and electric shock 'therapy'. In addition, the government and the public assume medical 'treatment' is in the best interests of both the patient and society, and great autonomy is given to physicians to determine the best course of treatment (Conrad and Schneider, 1992; Goffman, 1961; Snyder and Mitchell, 2006). Incarceration in prisons, however, seems to be operating more under the discourses of punishment and retribution, rather than rehabilitation. This framework has its own lethal effects on the lives of those incarcerated and formerly incarcerated, but it does not necessarily operate under the same processes as medicalized settings, although both settings have many similarities (Chapman et al., forthcoming).

Connecting Institutionalization and Imprisonment in the Social Sciences

On a theoretical level, the imperative to understand incarceration through both the prism of the prison but also that of the institution, as this article suggests, is crucial to understanding the underlying relations that legitimate confinement in a variety of settings. Such analysis also underscores the relation between penal and medical notions of danger, as they relate to both criminalization and medicalization and labeling. Historically, the connection between imprisonment and definitions of 'abnormality' seems to have arisen out of a new configuration of notions of danger.

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From the 19th century the webs of the medical and the judicial start to intertwine with the rise of a hybrid discourse, according to Foucault (2003). Its hybridity lies not just in the sense of amalgamation of several discourses (legal, medical) but also in the creation of a new power/knowledge structure in which 'doctors laying claim to judicial power and judges laying claim to medical power' (2003: 39) lay down an intertwined system of surveillance, which includes psychiatric progress reports on the incarcerated, examination in court of the accused, and surveillance of 'at risk' groups. According to Foucault (2003), this medico-judicial discourse does not originate from medicine or law or in between, but from another external discourse – that of abnormality. The power of normalization is cloaked by medical notions of illness and legal notions of recidivism. The history of treatment and categorization of those labeled as feebleminded, and later mentally retarded, is also paved with cobblestones of notions of social danger, as prominent eugenicists tried to 'scientifically' establish that those whom they characterized as feebleminded had a tendency to commit violent crimes. In the late 19th century, as the eugenics movement gained momentum, it was declared that all feebleminded people were potential criminals (Rafter, 1997; Trent, 1995).

Spaces of confinement themselves, such as psychiatric hospitals, poorhouses, prisons and institutions for those labeled as 'mentally retarded', could also be perceived as operating on similar logic, from a variety of perspectives. Foucault analyzes their discursive formations and effects as docile making and producing techniques of governance and social control (1995). The 'remarkable continuity of confinement' (Harcourt, 2006) is also discussed as part of a revisionist social history of places of confinement, offered by Rothman (1971), Grob (1972, 1983), Scull (1979, 1989) and Foucault (1965, 1987, 1995) and amended by feminist historians and criminologists such as Rafter (2004) and Kurshan (1996). The revisionist narrative marked a shift from perspectives that saw asylums and prisons as reforming and benevolent, to more nuanced accounts that critiqued both the consequences and intentions of reform efforts that ended in mass incarceration. Interestingly, this neo-historiography of the institution and prison was written, and battled, by historians and other intellectuals at a time when these institutions started to lose their legitimacy. Most of these accounts were produced in the 1960s and 1970s when larger exposes, lawsuits, novels, movies and ethnographies came out to reveal the decrepit conditions of asylums, hospitals and prisons. These included Erving Goffman's *Asylums* (1961), the novel made into a Hollywood film *One flew Over the Cuckoo's Nest* (Kesey, 1962), Burton Blatt's exposé *Christmas in Purgatory* (Blatt and Kaplan, 1974), the riots in Attica prison, and lawsuits on behalf of prisoners and inmates in state institutions. Therefore, the debates over the reasons and usefulness of asylums in the past should be read as directly tied to debates over decarceration and re-institutionalization at present. The premise that all these writings share is an understanding of incarceration as a continuum and not an isolated phenomenon that can be understood by engaging with only one locale.

Goffman's analysis became a popularized sociological account that analyzed all such edifices as 'total institutions,' in which the incarcerated populations are subjected to stripping of their identities and processes of dehumanization (Goffman, 1961). In addition, the citizenship and personhood of those incarcerated is questioned when living in such institutions. This can be done in the form of taking away or denying voting rights, as is the case for felons and many people with labels of intellectual disabilities, or for women, denying reproductive rights when living in prisons and nursing homes. These populations were also targets of medical experiments in institutions and prisons. Such connections, which stress the similarities of total institutions beg us also to emphasize the importance of moving away from analogies (institutions are like prisons for example) into thinking more intersectionally about their interrelated nature.

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Imprisonment in prisons and in institutions are not only related in a theoretical or historical realm. On an empirical level, Harcourt (2006) emphasizes that using an aggregated incarceration rate, which includes data from hospitalization and imprisonment combined, yields very different results and implications for research and policy. Harcourt (2006) laments that none of the above literature, which connected prisons and institutions (for example the work of Foucault and other historians of asylums, the work of Goffman on total institutions, etc), made its way to social scientific research, especially to its empirical/quantitative dimension (with the exception of studies that look into the phenomenon of trans-incarceration, discussed later). In other words, none of the studies that include confinement as an independent variable includes institutionalization in its measure and definition of confinement/incarceration. In social science research, including criminology, the convention is to think of confinement in terms of placement in jails and prisons, therefore reinforcing a skewed interpretation of 'the rise in incarceration' in the USA. Under this interpretation, the first half of the 20th century is conceived as an era of relative stability in terms of incarceration, with an explosion in this area in the 1980s onward, in the form of immense growth in the capacity of prisons and jails. However, as Harcourt (2006) suggests, if the data on mental hospitalization and institutionalization were also covered in such studies under the prism of incarceration, then the 'rise in incarceration' would have reached its peak in 1955, when mental hospitals reached their highest capacity. Put differently, the incarceration rates in prisons and jails today (although appallingly high by any standards) barely scrape the levels of incarceration during the early part of the 20th century because of the then massive confinement in hospitals.

Therefore, Harcourt (2006) argues for the use of aggregated incarceration rates, by using figures for imprisonment and institutionalization combined, for all future research that examines the relation of confinement to other factors such as homicide, employment, education, crime, etc. Not to do so is to look at only a partial picture of both confinement and incapacitation and also not to take seriously the theoretical and historical perspectives that conceptualize incarceration more expansively. What needs to be empirically assessed, then, is not 'the rise in incarceration' but the systemic and lingering effects of the continuity of confinement in modern times. What such arguments highlight is the need to reconceptualize institutionalization and imprisonment as not merely analogues but as in fact interconnected, in their logic, historical enactment and social effects. The theoretical and policy implications of such interconnectedness will also necessitate bringing in disability (psychiatric, developmental, physical, etc.) as a focus in studies on incarceration, as well as working out questions of criminality and danger in studies of institutionalization and disablement.

Political Economy and the Institution-Prison-Industrial Complex

Political economy could be applied as a useful framework from which to uncover the connections between the construction of disability and criminality, as another explanatory scheme for the growing usage of confinement in capitalist societies. Class based analysis of disability urges us to shift our understanding of disability oppression from discussions of stigma and deviance to that of systematic economic exclusion of people with disabilities. In such Marxist inspired accounts, the conditions of being (socio-economic location) are seen as core producers of particular ableist attitudes and ideologies, and not the other way around. Thus, several disability studies scholars point to the need to move beyond models of disability rights to revealing the systematic exclusion of people with disabilities from sites of production, exchange and, to a lesser extent, consumption (Ben-Moshe et al., 2009; McRuer, 2006; Oliver, 1990; Russell, 1998, 2001). Charlton (1998) sees disabled people as surplus population, those who do not even serve as part of what Marx termed

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the 'reserve army of labor', a resource tapped into during economic expansion or crisis. They are essentially the underclass. In fact, the definition of unemployment itself historically excludes disabled people, illegal immigrants, retired people (who often wish to work), and women (who do unpaid labor).

Under a neo-Marxist analysis, disability is an ideology upon which the capitalist system rests, because it can regulate and control the unequal distribution of surplus by invoking biological difference as the 'natural' cause of inequality (Erevelles, 1996; Stone, 1994). Work is central to industrial societies, not only as means to get life's necessities but also to establish certain kinds of relations with others, which are valued within these societies (Oliver, 1990). Industrialization and the advent of capitalism not only posed a problem for disabled people's participation in the work force (which now required greater speed, stamina and rigid production norms), but also excluded disability as part of mainstream society. In addition, disabled people were often blamed for the changed mode of production (Nibert, 1995). Hierarchical relations that were once a divine right became an economic rule that need to be justified by such ideologies as eugenics, meritocracy and the increasing need for 'skilled and educated' labor, which exclude those who are labeled as uneducable because of disability and other factors (Nibert, 1995). Thus, disabled people have increasingly found themselves marginalized within segregated settings such as institutions and 'special' education (Oliver, 1990). Under this formulation, disabled people mark, with their different bodies and minds, the boundaries of normalcy. They serve as an ideological reminder of the fate of those who do not participate in capitalist production. The notion of disability is so intertwined with perceived inability to work that if a person is able to work, they cannot be regarded as disabled, according to social security administration in the USA, for instance.

All societies function through principles that distribute goods and services among the entire population. Stone (1994) argues that in capitalist societies the major distributive mechanism is work – but not all are willing or able to work. Therefore a second distributive mechanism is established, which is based on need. With the rise of capitalism, disability became the category through which people are measured as need based or work based. Such interpretations dispel the common belief that people with disabilities are not productive under the capitalist system, since they do not hold jobs. In fact, many (including policy makers) believe that disabled people are a strain on the economy, especially under neoliberal ideology. But political economists argue that disability supports a whole industry of professionals that keeps the economy afloat, such as service providers, case managers, medical professionals, health care specialists, etc. (Charlton, 1998; Oliver, 1990).

Human services have traditionally been regarded as moral enterprises that service and assist people in need. However, according to Wolfensberger (1989), the latent function of this industry is self preservation and expansion – often at the expense of the users of these services. As Oliver explains so eloquently:

> [under capitalism] the production of the category of disability is no different from the production of motor cars or hamburgers. Each has an industry, whether it be the car, fast food, or human service industry. Each industry has a workforce which has a vested interest in producing their product in particular ways and in exerting as much control over the process of production as possible. (Oliver, 1990: 126)

Human services are a major component of contemporary western economy, especially with the decline in agriculture and manufacturing jobs and must remain significant in order to perpetuate the structure of modern post-industrial societies (Wolfensberger, 1989). Unemployment and low incomes are then maintained by a class whose employment is derived from these deprived populations, such as case manager, social workers, probation officers, and health care/mental health administrators.

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The advent of neoliberalism and workfare programs shifted the discourse around 'deserving and undeserving' populations so that today in many 'industrialized' OECD countries even those perceived as deserving of public assistance, such as those who are deemed disabled, are being pushed into the labor market through workfare programs, despite the lack of jobs, and the inaccessibility of the capitalist enterprise as a whole. This discourse shifts the understanding of disability as a category under 'the reserve army of labor' to a population being surveilled for political-economic reasons. The increased surveillance of welfare recipients (see Wacquant, 2009) can also be observed today as used on disability benefits recipients especially by agencies granting the services with the use of home visits, complicated verification systems and even the hiring of investigators to follow specific recipients to ensure the authenticity of their disability. Loic Wacquant (2009) further discusses the ways in which workfare and prisonfare (increased criminalization and incarceration of unwanted populations mostly based on race and class) operate as the left and right arm of the state, and cannot be separated. He asserts that the failure of welfare and workfare to alleviate poverty implies that the main aim of such policies is not to decrease poverty levels but to survey and surveille the poor and keep them as invisible as possible from the social and cultural landscape (Wacquant, 2009). The second mechanism used to criminalize the poor is the increased use of incarceration. This tactic makes the underemployed, including those who are disabled, disappear from the public scene, both literally (as they are warehoused in a variety of internments) and figuratively in statistics and policy analysis of unemployment, which do not count prisoners and institutionalized members.

I suggest that the forces of incarceration of disabled people should be understood under the growth of both the prison industry and the institution-industrial complex, in the form of a growing private industry of nursing homes, boarding homes, for-profit psychiatric hospitals and group homes. Some of the major corporations in the institution/hospital industry in North America are Res-Care; Beverly Enterprises of Fort Smith, which employs more people than the entire automobile industry; Healthsouth rehabilitation corporation; Columbia/HCA hospital chain; Humana, and Summit Health. Disability and deinstitutionalization advocates claim that although costs vary by state and place of confinement (state funded, private, or veteran run), it is cheaper to financially sustain a disabled person, with supports, in the community than it is to institutionalize them (Russell, 1998). These cost estimates raise an ongoing debate – as it is hard to compare community placement, with minimal supports as it is now, to institutions that have an array of services embedded within their costs. What is clear though, from looking at governmental policies, is that the institutional bias (i.e. the impetus to institutionalize people with disabilities instead of providing them with supports to live in the community with the same funds) is embedded in Medicaid policies in the USA, for example, and also represented in current legislation and lobbying efforts (Lerman, 1985). The American Health Care Association, for instance, which represents for-profit nursing homes and care facilities, is one of the biggest financial contributors to the campaigns of federal candidates (Russell, 1998).

This bias means that public funds (in the form of benefits or waivers) goes towards institutions, nursing homes or group homes but not to the person who benefits from these services directly. In the USA, the introduction of Medicaid waivers mostly applies to alternative institutions (nursing homes, hostels) and not alternative care. There is a lack of reimbursements that could cover services such as non-hospitalization long term treatment, day and vocational habilitation, advocacy and support for living in the community. The consequence is that most people with disabilities do not have real choices in terms of whether and with whom they would like to live, if their main source of funding is federal benefits. Many disability advocacy organizations in the USA, most prominently ADAPT, therefore support any initiatives, such as Money Follows the Person,

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Medicaid Community Attendant Services Act (MiCasa) and the Community Choice Act, that enable people to utilize their benefits and waivers as they see fit, to hire their own aids and to enable them to live an integrated life in community settings of their own choosing.

In short, in post-industrial times, disablement has become big business. A single impaired body generates tens of thousands of dollars in annual revenues in an institution. From the point of view of the institution-industrial complex, disabled people are worth more to the gross domestic product when occupying institutional 'beds' than they are in their own homes (Russell and Stewart, 2001). Capitalism has found a solution to the 'problem' of unproductiveness, for those who are not perceived as laborers. Their bodies generate revenues when placed in institutional beds, such as large institutions, nursing homes, prisons and (some) group homes. This is the logic of handicapitalism, as Russell (1998) refers to it. This political-economic analysis of institutionalization should be further investigated by scholars who are interested in understanding the phenomenon of mass incarceration through an intersectional lens.

Disability Studies, Sociology and Psychiatric and Developmental Disabilities

The field of disability studies can be credited for 'shifting the margin to the center' (hooks, 2000) in relation to the critical study of the construction of normalcy and lived reality of disability. Feminists and critical analysis of disability brought to the forefront a new conceptualization of disability, not just as a socially excluded category, but as an embodied identity (Thomson, 1997; Wendell, 1996). This focus on embodiment challenges the medical model of disability, which conceives of disability as a lack and deficiency inherent in non-normative bodies. It also challenges the social model of disability, which encourages us to focus solely on processes of disablement as a critical framework that will end the oppression of people with disabilities (Morris, 2001; Tremain, 2002).

However, one major critique of such an enterprise is the concern of overrepresentation of the body and visible disabilities in the field of disability studies. Such focus obscures the myriad disabilities and impairments that could and should be analyzed under the purview of disability studies. For instance, Rosemarie Garland Thomson's work, which has been central to the field of disability studies, focuses on freak enactments, visible anomalies, ethics of staring, and disability as a visual modality (1997, 2000, 2002, 2009). However, there is very little focus in this formulation of disability studies on cognitive/intellectual, developmental, learning and even psychiatric disabilities. Another noted example could be found in the seminal book *Cultural Locations of Disability* (2006), in which disability studies theorists David Mitchell and Sharon Snyder contend that until the publication of *Abnormal* (2003), Michel Foucault did not explicitly engage with disabled bodies. But what about insane bodies, which are the focus of much of Foucault's work (1965, 1987)? Are they not considered disabled, and if so, why not? Is the purview of disability studies so bound up by the experience of physical impairments that other disabling embodiments become the exception to the rule?

I want to be clear that I am not trying to suggest that the experiences and analysis of various impairments and forms of oppression should be conflated into one meta-field, called disability studies. And I am not suggesting that being psychiatrized or being labeled intellectually disabled or having a physical or sensory disability are all the same. What I am trying to push for is the understanding that the logic of normalcy (Davis, 1995) and compulsory ablebodiedness (McRuer, 2002) operates on all these fronts and needs to be analyzed in concordance with all of these different embodiments and discourses. I suggest that the emergent difference between these

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experiences, and now scholarly fields, needs to be studied and understood as a contingency, not taken as an axiom.

There are many commonalities that could be traced between the discourses of disability studies, critical study of developmental disabilities and mad studies. Firstly, of course, one needs to acknowledge the intersectional nature of oppressions, impairments and ways of being in the world. Therefore, many people with sensory or developmental disabilities, for example, feel the stress of living in an ableist and inaccessible world and thus may share experiences with those who are psychiatrized or become psychiatrized themselves. In addition, many people who have been psychiatrized or institutionalized may have physical or sensory impairments due to the effects of medications and the nature of being incarcerated in hospitals (Beresford, 2000).

Most notably, many in these movements share goals of fighting for 're-symbolization' and meaning (Thomson, 2002). For instance, these fields share a process by which terminology such as 'crip' and 'mad' have been reclaimed and reaffirmed as legitimate, not to mention chic, identity formations as opposed to diagnostic labels that signal lack and pathology (Lewis, 2006). The disabled/psychiatrized identity is thus seen either in a matter of fact way or as a valued identity one possesses, in a similar vein to queer identities or the new concept of 'deaf gain' as opposed to 'hearing loss' within deaf culture (Bauman and Murray, 2009). These processes can also be observed, albeit in different ways, in recent campaigns in the USA to end the use of the 'R word'[2] as it is seen by self-advocates[3] as oppressive and antiquated. Moreover, such frameworks emphasize systemic ways of oppression based on perceived difference, as oppose to other frameworks that put the source of blame and stress on the person and not on social structures. In disability studies, such systems of oppression have been termed forms of handicapism (Bogdan and Biklen, 1977), ableism, normalcy (Davis, 1995) and disablement (Oliver, 1990), and in mad studies the emphasis is on sanism or mentalism (Chamberlin, 1978; Perlin, 2000).

Another connecting point between these various scholarly discourses is that in the public's eye, and often in public policy, people who are psychiatrized and those who are labeled as intellectually or physically disabled all share a common label in administrative categorization, the gathering of statistics and bureaucratic definitions – the label of 'disability' (Beresford, 2000). This is done despite the resistance of some of these groups seeking to escape from the label of disability, as an administrative label or self-definition. For instance, many with psychiatric labels do not identify as disabled and see their life circumstances as significantly different from those of people with disabilities (Lewis, 2006). But even if certain groups or individuals resist the impetus to collide all these categories, often in social policy, legislation and service provision they are lumped together nonetheless. This collision of many subject formations into one administrative category can be seen as a bio-political tool of population control and management, and therefore as a form of governmentality (Foucault, 2010).[4]

However, this process also allows for the creation of powerful new coalitions that have the potential to implode or resist these categorizations from within. All these counter-hegemonic discourses resist the impetus of normalization (Davis, 2002), medicalization and the authority of medical 'experts' (Foucault, 1965; Zola, 1991) and especially labeling for diagnostic and prescriptive use on the bodies and minds of disabled people. They resist the trumping of narratives of cure, and insist on access, social justice and rights instead (or in some formulations- in addition). Most importantly, these discourses and scholarly fields break the dichotomy between 'normal' and 'pathological' and leave bio-diversity as a continuum of ways of living in the world, and not a binary with hierarchies attached.

I thus argue that disability studies could benefit immensely by actively taking up the theorizations and lived experiences in the field of developmental disability and mad studies. In relation

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to the sociological study of incarceration, what such expansive formulations achieve is an understanding of incarceration in its broadest sense in relation to hospitalization, institutionalization and imprisonment and a fuller understanding of the forces that construct medicalization and criminalization.

Trans-incarceration: From Balloon Theory to Reconceptualizing Incarceration

Another area of research at the intersection of institutionalization and incarceration arises from the idea that after deinstitutionalization many of those deinstitutionalized ended up in prisons and jails. This move from one carceral space to another has been termed trans-incarceration and is much debated in the sociological literature. When looking at general trends, it is easy to interpret the data as a hypothesis of medicalization giving way to criminalization over time. When examining incarceration rates, one can stipulate that psychiatry had the strongest hold on taking charge of social problems in the first half of the 20th century, culminating in over a quarter of a million people in mental hospitals in 1955. From the 1960s the mental inmates' population decreased but the prison population increased (Liska et al., 1999). The shrinkage of the safety net from the Reagan era to the 1990s, coupled with increased federal expansion of the corrections operation created in essence a tradeoff between social services and incarceration. Wacquant (2009) and others (see Dear and Wolch, 1987; Isaac and Armat, 1990; Torrey, 1996) thus argue that the shift from medical and social services to penal and surveillance measures can be seen in the treatment of people with psychiatric disabilities, which reiterates the claims that deinstitutionalization resulted in re-incarceration of mentally ill people in jails.

This relationship, of reversal of the trends between the mental health and the criminal systems, is hardly new, however, and has been studied over the years by many social scientists who have nicknamed this phenomenon 'the balloon theory'. As early as 1939, Penrose suggested that social control evolves from incarcerating people to treating people, therefore suggesting an inverse relationship between the mental health and prison systems. Since then, this hypothesis has been tested numerous times with inconsistent results. Trans-institutionalization of juvenile offenders happened repeatedly in the 1970s, when reform schools depopulated while numbers in psychiatric or child welfare institutions increased. Jerry Miller, who was the commissioner who decided on decarceration of all juvenile facilities in the state of Massachusetts in the 1970s, comments that this was not the same kids simply being moved from one institution to another, but instead represents a system change that is a core component of the institutional system (Miller, 1991). Institutions tend to reproduce themselves, only the populations change in the meantime.

The major hypothesis of such claims is that the mental health system reroutes individuals into the criminal justice system, via arrests and placement in jails and prisons. Overall, studies suggest that in relation to arrests, this hypothesis may be corroborated, as the percentage of mental patients with prior arrests had increased from the 1940s to the 1970s. But studies of imprisonment seem less conclusive, suggesting that some inmates end up in jails after being arrested, but not so much in prisons (Liska et al., 1999). The research conducted by Liska et al. (1999) finds no support for the hypothesis that a decrease in hospital capacity would lead to an increase in the capacity of jails and prisons, which they term the 'functional-alternative' thesis. They did find, however, some support for the conduit thesis, which means that the criminal justice system operates as a conduit to the mental health system, but not vice versa. The movement of some people from jails and prisons and into hospitals could be done by official transfers decided upon by a judge and based on a

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psychiatric evaluation, or it could be based on less official means such as plea bargains for reduced time or an individual decision that hospital time is better than time in prison.

Steadman et al. (1984) researched the relationship between the mental health and prison systems in the aftermath of deinstitutionalization of psychiatric hospitals. They used both a comparative and a longitudinal approach. Their study randomly selected a total of 3897 male prisoners and 2376 adult male admittees to state mental hospitals from six different states, half from 1968 and the other half from 1978. They gathered full institutional histories for arrests, imprisonment, and state mental hospitalization for each inmate and then compared the system overlap between 1968 and 1978, thus enabling them to measure the extent of trans-institutionalization. Their results indicated that Texas experienced a huge increase, California and Iowa had increases as well, but New York, Arizona, and Massachusetts experienced proportional declines. Steadman et al. (1984) concluded from these data that there was little evidence of massive transfer from mental hospitals to prisons. But they did find evidence to suggest that mental hospitals were becoming more 'criminal', in that the number of mental hospital admittees with one or more prior arrests increased by an average of 40 percent.

Taking incarceration in its broadest terms, (in relation to both prisons and institutions), would entail deconstructing the categories that are used by criminologists, psychiatrists and social scientists. The point will not be to try and find the most accurate way of measuring 'the mentally ill' in prisons and jails, but to ask questions which take into account the blurry line between criminality and medicalization. For instance, instead of discussing 'the rise in incarceration' as a single-faceted phenomenon, examining it in conjunction with previous rates of institutionalization would enable one to see if the criminal justice system widened its net to include those who were previously incarcerated in institutions and asylums (Harcourt, 2006). However, the assumption that these are the same people (i.e. that people were deinstitutionalized and ended up in prison), should also be deconstructed as the demographics of each of these populations as a whole are quite distinct. Over the years, the gender distribution of inmates in mental hospitals tended to be either equal or tended towards overrepresentation of women. However, in terms of imprisonment, the majority of those imprisoned are male. There are differences in terms of age and race/ethnicity as well. Although there is some evidence to suggest that during deinstitutionalization the proportion of people of color had increased for those admitted to mental hospitals, the proportion still stood at about a third at its highest point (Steadman et al., 1984). As should now be clear to anyone familiar with the prison system in the USA, people of color are highly overrepresented, reaching over 50 percent in the early 1990s. Put differently, generally speaking, the inmate population in mental hospitals tended to be white, older and more equally distributed by gender then those incarcerated in prisons (Harcourt, 2006). Therefore, we are not speaking about the same population, but of ways in which the social control function of incarceration retained its importance, but for differing populations.

A critique of Harcourt's pioneering work is that even he, in his call for inclusion and broadening the scope of current research, neglects to take into account the rates of institutionalization in a variety of confinement spaces. The rates of incarceration that he describes are made up of rates of hospitalization in psychiatric hospitals and those of incarceration in prisons. Another huge body of literature and data that is omitted from the analysis is that of incarceration in institutions specifically created for those labeled as 'mentally retarded'.[5] It would be interesting to extend that analysis in terms of aggregated data sets in a similar vein to Harcourt's transfiguration but also to include other institutions such as those for people with developmental disabilities, and nursing homes. Such an analysis would truly broaden the scope of incarceration and take into account the lived experiences of those who are housed in such settings as carceral spaces.

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Prisoners with Disabilities at the Intersection

Another set of studies that examine the connection between medicalization, criminalization and imprisonment is the gathering of statistics around the prevalence of disability, especially labels of mental illness and mental retardation, among the imprisoned population. Statistics on 'criminally mentally ill' or people with mental illness diagnoses in jails and prisons are generally hard to come by, especially historically. This is one of the reasons why claims of increasing rates of mental illness in prisons post-deinstitutionalization is hard to support, as there is no comparative data pre-deinstitutionalization that can be used as a baseline for such comparisons. Although several attempts have been made to estimate the number of prisoners who have a psychiatric diagnosis, it is impossible to quantify their number with any degree of precision, even if taking the label of 'mental illness' as a viable construct. The American Psychiatric Association reports in 2000 that 'up to 5% [of prisoners] are actively psychotic' and that as many as one in five prisoners were seriously mentally ill (APA, 2000: xix).

Other attempts to estimate their prevalence appear to have used a substantially more expansive definition of mental illness. The Bureau of Justice Statistics (1999) reports that 16 percent of state prison inmates either identified as having 'a mental condition' or having stayed overnight in a mental hospital. The statistics for women prisoners are particularly stark. The same study by the Bureau of Justice Statistics based on a survey of prisoners, found that '29 percent of white females, 20 percent of black females and 22 percent of Hispanic females in State prison were identified as mentally ill. Nearly four in ten white female inmates aged twenty-four or younger were mentally ill' (BJS, 1999).

Even when taking the construct of 'mental retardation' as a pure label, which is dependent on socio-historical power/knowledge paradigms, there is no precise measurement for the number of prisoners who are labeled as mentally retarded. A policy brief states that while those with intellectual disabilities comprise 2 to 3 percent of the general population, they represent 4 to 10 percent of the prison population, with an even greater number of those in juvenile facilities and in jails (Petersilia, 2000). One study that looked at the number of people with disabilities in state and federal prisons found that less than 1 percent of inmates had physical disabilities while 4.2 percent had 'mental retardation' (Veneziano and Veneziano, 1996). It is also important to note that the construct of 'mental retardation' cannot be entirely separated from that of 'mental illness', as there are many, especially those who end up in prisons and jails, that are labeled as both, and the types of discrimination they are facing is compounded by unfounded beliefs and lack of services in relation to both disabilities.

Analyzing imprisonment from a disability studies lens will necessitate a closer look at the social and economic conditions of disablement and incarceration rather than looking at disability as a cause for criminal acts. Prisoners are not randomly selected and do not represent all statuses of society. The majority of prisoners are poor, and are people of color. Poverty is known to cause a variety of impairments and disabling conditions. In addition it is crucial to emphasize that the prison environment itself is disabling – from hard labor in toxic conditions and materials to closed wards with poor air quality, circulation of drugs and unsanitary needles, and lack of medical equipment and medication (Russell and Stewart, 2001). It is also crucial to take an expansive view of what constitutes 'disability' in such environments. For instance, the high prevalence of HIV/AIDS among prisoners and the various impairments that come with aging in a disabling environment such as a prison, as a result of prolonged sentencing policies, should be analyzed critically by sociologists and disability studies scholars. Disability in this framework is not a natural biological entity, but related to economic and social conditions that lead to an increased chance of both disablement and imprisonment.

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Regardless of the percentages, it has become clear that while in prisons or jails, those with disability or psychiatric diagnoses are often discriminated against. Far too frequently, when there is no serious effort to provide mental health treatment, the only semblance of treatment offered is psychotropic medication, and often in such circumstances it is ill prescribed and controlled (see American Association on Mental Retardation, 2005). Because of lack of access, prisoners with physical disabilities cannot leave their cells, including going to the bathroom or showering. The lack of basic human needs in the penal system is brought to full light in the heart wrenching stories of prisoners with disabilities. Like in the case of Newman v. Alabama, finding systemic constitutional violations of prisoners' rights in the Alabama prison system, including the death of a quadriplegic inmate, who spent many months in the hospital confined to a bed, leading to bedsores, which developed maggots from lack of care 'until the stench pervaded the entire ward' (see ADAPT, 2005). What such horrific stories show is not the uniqueness of the disability experience behind bars, but both systemic disablement within society at large and the inherent cruelty and inhumanity of the penal system as a whole.

Similarly, conditions of confinement may cause further mental deterioration in prisoners entering the system with diagnoses of 'mental illness' or intellectual disabilities. Most court cases show that the right to (re)habilitation is often not fulfilled in jails, prisons and institutions, and that this further distresses those incarcerated and worsens their mental and physical health overall. Those incarcerated (in institutions or prisons) with labels of intellectual disabilities may in fact lose crucial life skills that they had before they were imprisoned such as 'loss of the ability to communicate, perform daily self-care, remain physically safe, and to maintain even rudimentary emotional stability' (American Association on Mental Retardation, 2005). Prisoners who are identified as mentally ill or exhibit 'disruptive behaviors' are often sanctioned to 'administrative segregation' in separate units, which are often isolation units. These segregated forms of incarceration, such as supermax or SHU (security housing units), are likely to cause or exacerbate mental and physical ill-health of those incarcerated. Haney (2003) lists 'rage, loss of control, paranoia, hallucinations, and self-mutilations' as some of the adverse effects prisoners secluded in supermax and solitary confinement had experienced.

The reason why these figures are so crucial is because there is much at stake in counting the percentage of disabled prisoners, in terms of research, policy and activism. In terms of policy and legislation, it is clear that if one can prove sufficiently that there is a large percentage of prisoners with a specific disability, then it would require a specific solution such as requesting more hospital units to be built in specific prisons or prescribing more medications on a particular unit. For activists, using statistics that demonstrate the high prevalence of disabled prisoners could lead in several directions. If one is an activist in NAMI (National Alliance of Mental Illness), for instance, then these statistics are used to show that deinstitutionalization failed and that prisons and jails had become a dumping ground for those labeled as mentally ill with the lack of other alternatives. Such campaigns, which have been ongoing since the early 1990s, call in essence for the (re)hospitalization of those with psychiatric diagnosis (see Torrey, 1996 for example). However, if one is an activist in broader or more radical social justice initiatives, they might use these statistics to showcase the cruelty of the criminal 'justice' system and call for the just treatment of all prisoners (such as abolishing the use of isolation units or forced medication overall). The downturn of such arguments, much like those in the calls to abolish the death penalty for those who are labeled as intellectually disabled, is that they can turn into arguments that reproduce ableist rhetoric and may seem to call for the release of some prisoners (i.e. those most disabled) but not others.

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Conclusion: The Incarceration Matrix and the Sociological Imagination

This article was intended as a beginning to an overdue conversation between the growing scholarship on incarceration and research in the critical field of disability studies, by conceptualizing disability and incarceration very broadly. Incorporating a variety of forms of disablement within disability studies (in relation to psychiatrization, labeling of those with intellectual disabilities and institutionalization) will hopefully generate more nuanced accounts of what gets codified as disability as well as what gets to be labeled, and researched, as incarceration. Broadening the scope of research on incarceration to include a variety of confinements (such as psychiatric hospitals, nursing homes, institutions for those labeled as intellectually and developmentally disabled) will take into account the work of scholars who have already theorized the carceral along these lines (such as Foucault, Goffman, Scull and others) and can also generate new work in this vein. It will also account for the lived reality of prisoners with disabilities who are caught in the webs of the institution- and prison-industrial complexes. Under this formulation, incarceration is understood as a continuum of carceral edifices, or as an institutional matrix in which disability is a core component, not simply an added category of analysis.

This call for connecting analysis of incarceration with disability is also a call to pay attention to the lives of mostly poor people of color who are still incarcerated worldwide in nursing homes, institutions for those with labels of mental illness and/or intellectual disability and prisons, and bring their perspective to bear on what Chris Bell characterized as 'White disability studies' (2006). My main argument here is that the history of disability is the history of incarceration. Following this argument will lead us back to the original premise of the sociological imagination. As Mills explains, 'The sociological imagination enables us to grasp history and biography and the relations between the two within society. That is its task and its promise' (1959: 6). Therefore, sociologists who study incarceration and those who are interested in the lived experience of people with a variety of disability labels would fare well with a more expansive view of both disability and incarceration.

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Notes

1 Throughout the article I refer to people with intellectual and developmental disabilities and people with labels of mental illness. For the purposes of this article, these refer to the same two populations but using different terminology derived either from the people first movement (i.e. people with developmental disabilities) or more historically accurate terminology derived from the way people were referred to in public policy up until a few years ago (i.e. the category of mental retardation). Most of the time I choose to use the terms derived from disability studies and labeling theory, which view these categories of 'disability' as socially constructed. I therefore mostly refer to people as 'people labeled as mentally ill' to indicate that I perceive these categorizations as situational and varied over time, culture and power dynamics as to who gets to define and who gets to be defined under these categories.

2 'R word' refers to the use of the category of mental retardation, which is rejected by self-advocates who are labeled by this category and view it as offensive. They push for the abolition of the term and replacing it with terms such as developmental disabilities for administrative use, or others push for no labels as can be seen in the re-emergence of the slogan 'label jars not people' by the People First movement in the USA. See http://www.r-word.org/ for more details.

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3 Self advocates are people with labels of intellectual/cognitive disabilities who are involved in disability advocacy and activism.
4 Recent work by Jasbir Puar (2009) further challenges identity politics in disability studies and activism and demonstrates the porous boundaries between capacity endowed and debility laden bodies, by using the categories of risk, statistical probability, and prognosis, which if taken seriously transform our understanding of ability and identity from being an essence into being codifications of risks and their management by subjects and the state.
5 The scope of the larger project, out of which this article is derived, takes seriously Harcourt's suggestion in terms of theoretical and conceptual underpinning that what is considered incarceration includes those incarcerated in prisons, asylums, training schools, institutions for those labeled as intellectually disabled and psychiatric hospitals. It primarily connects the activism of prison abolition and deinstitutionalization as movements that aim to close down 'total institutions' in the USA (see Ben-Moshe, 2011).

References

ADAPT (2005) Brief for American Disabled for Attendant Programs Today et al. as Amici Curiae in Support of Petitioners, *Goodman v. Georgia*, No. 02-10168, 11th Circuit (July 29, 2005).

American Association on Mental Retardation (2005) Brief of the American Association on Mental Retardation et al. in Support of Petitioners, *Goodman v. Georgia*, No. 02-10168, 11th Circuit (July 29, 2005).

APA (American Psychiatric Association) (2000) *Psychiatric Services in Jails and Prisons*. 2nd Edition. Washington, DC: American Psychiatric Association.

Bauman D and Murray S (2009) *Reframing: From Hearing Loss to Deaf Gain*. *Deaf Studies Digital Journal* 1(1). Available (consulted 6 August 2011) at: http://dsdj.gallaudet.edu/

Bell C (2006) Introducing white disability studies: a modest proposal. In: Davis LJ (ed.) *The Disability Studies Reader*. 2nd Edition. New York, NY: Routledge, 275–282.

Ben-Moshe L (2011) Genealogies of resistance to incarceration: abolition politics in deinstitutionalization and anti-prison activism in the U.S. Unpublished dissertation, Syracuse University, NY.

Ben-Moshe L, Hill D, Nocella AJ II and Templer B (2009) Dis-abling capitalism and an anarchism of 'radical equality' in resistance to ideologies of normalcy. In: Amster R et al. (eds) *Contemporary Anarchist Studies*. New York, NY: Routledge Press, 113–122.

Beresford P (2000) What have madness and psychiatric system survivors got to do with disability and disability studies? *Disability and Society* 15(1): 167–172.

BJS (Bureau of Justice Statistics) (1999) *Mental Health and Treatment of Inmates and Probationers*. Washington, DC: US Department of Justice.

BJS (Bureau of Justice Statistics) (2008) *Census of State and Federal Correctional Facilities 2005.* Washington, DC: US Department of Justice.

BJS (Bureau of Justice Statistics) (2010) *Correctional Populations in the United States 2009.* Washington, DC: US Department of Justice.

Blatt B and Kaplan FM (1974) *Christmas in Purgatory: A Photographic Essay on Mental Retardation*. Syracuse, NY: Human Policy Press.

Bogdan R and Biklen D (1977) Handicapism. *Social Policy* 7(5): 14–19.

Braddock D (ed.) (2002) *Disability at the Dawn of the 21st Century and the State of the States.* Washington, DC: American Association on Mental Retardation.

Braddock D, Hemp R and Rizzolo MC (2008) *The State of the States in Developmental Disabilities: 2008*. Washington, DC: American Association on Intellectual and Developmental Disabilities.

Center on Human Policy (2004) The name assigned to the document by the author. This field may also contain sub-titles, series names, and report numbers. *'Community for All' Tool Kit: Resources for Supporting Community Living.* Center on Human Policy, Syracuse University. Available (consulted 7 February 2011) at: http://thechp.syr.edu/toolkit/

Chamberlin J (1978) On Our Own: *Patient Controlled Alternatives to the Mental Health System*. New York, NY: McGraw-Hill.

Downloaded from crs.sagepub.com at Univ of Illinois at Chicago Library on December 30, 2011

Chapman C, Ben-Moshe L and Carey A (forthcoming) Reconsidering confinement: interlocking locations and logics of incarceration. In: Ben-Moshe L et al. (eds) *Disability Incarcerated: Imprisonment and Dis/Ability in North America*.

Charlton JI (1998) *Nothing about Us without Us: Disability Oppression and Empowerment*. Berkeley, CA: University of California Press.

Collins PH (2000) *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*. New York, NY: Routledge.

Conrad P and Schneider JW (1992) *Deviance and Medicalization: From Badness to Sickness, with a New Afterword by the Authors*. [Expanded Edition] Philadelphia, PA: Temple University Press.

Crissey MS and Rosen M (1986) *Institutions for the Mentally Retarded: A Changing Role in Changing Times.* Austin, TX: PRO-ED.

Davis LJ (1995) *Enforcing Normalcy: Disability, Deafness, and the Body*. London and New York, NY: Verso.

Davis LJ (2002) *Bending over Backwards: Disability, Dismodernism, and Other Difficult Positions*. New York, NY: New York University Press.

Dear M and Wolch J (1987) *Landscapes of Despair: From Deinstitutionalization to Homelessness*. Princeton, NJ: Princeton University Press.

Erevelles N (1996) Disability and the dialectics of difference. *Disability and Society* 11(4): 519–537.

Ferguson P (1994) *Abandoned to their Fate: Social Policy and Practice toward Severely Retarded People in America, 1820–1920*. Philadelphia, PA: Temple University Press.

Foucault M (1965) *Madness and Civilization; A History of Insanity in the Age of Reason*. New York, NY: Pantheon Books.

Foucault M (1987) *Mental Illness and Psychology*. Berkeley, CA: University of California Press.

Foucault M (1995) *Discipline and Punish: The Birth of the Prison*. 2nd Edtion. New York, NY: Vintage Books.

Foucault M (2010) *The Birth of Biopolitics: Lectures at the College de France (1978–9)*. Picador Edition. New York: Palgrave MacMillan.

Foucault M (2003) *Abnormal: Lectures at the Collège de France, 1974–1975*. New York, NY: Picador.

Garland D (2001) *The Culture of Control: Crime and Social Order in Contemporary Society*. Chicago, IL: University of Chicago Press.

Gilmore RW (2006) *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California*. Berkeley, CA: University of California Press.

Goffman E (1961) *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. Garden City, NY: Anchor Books.

Gottschalk M (2006) *The Prison and the Gallows: The Politics of Mass Incarceration in America*. New York, NY and Cambridge: Cambridge University Press.

Gottschalk M (2010) Cell blocks and red ink: mass incarceration, the great recession and penal reform. *Daedalus* 139(3): 62–73.

Grob GN (1972) *Mental Institutions in America; Social Policy to 1875*. New York, NY: Free Press.

Grob GN (1983) *Mental Illness and American Society, 1875–1940*. Princeton, NJ: Princeton University Press.

Haney C (2003) Mental health issues in long-term solitary and 'Supermax' confinement. *Crime and Delinquency* 49(1): 134–156.

Harcourt B (2006) From the asylum to the prison: rethinking the incarceration revolution. *Texas Law Review* 84(7): 1751–1786.

Harcourt B (2011) *Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s*. University of Chicago, Law and Economics, Olin Working Paper 542; University of Chicago, Public Law Working Paper 335. Available (consulted 20 August 2011) at: http://ssrn.com/abstract=1748796

hooks b (2000) *Feminist Theory: From Margin to* Center. 2nd Edition. Boston, MA: South End Press.

Isaac RJ and Armat V (1990) Madness in the Streets*: How Psychiatry and the Law Abandoned the Mentally Ill*. New York, NY: Macmillan/Free Press.

Johnson AB (1990) *Out of Bedlam: The Truth about Deinstitutionalization*. New York, NY: Basic Books.

Downloaded from crs.sagepub.com at Univ of Illinois at Chicago Library on December 30, 2011

Johnson K (1998) *Deinstitutionalising Women: An Ethnographic Study of Institutional Closure*. Cambridge: Cambridge University Press.
Kesey K (1962) *One Flew over the Cuckoo's Nest: A Novel*. New York, NY: Viking Press.
Kurshan N (1996) Behind the walls: the history and current reality of women's imprisonment. In: Rosenblatt E (ed.) *Criminal Injustice: Confronting the Prison Crisis*. Boston, MA: South End Press.
Lakin KC, Larson SA, Salmi P and Webster A (2010) *Residential Services for Persons with Developmental Disabilities: Statues and trends through 2009*. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration.
Lerman P (1985) Deinstitutionalization and welfare policies. *Annals of the American Academy of Political and Social Science* May(479): 132–155.
Lewis B (2006) A mad fight: psychiatry and disability activism. In: Davis L (ed.) *The Disability Studies* Reader. 2nd Edition. New York, NY: Routledge, 331–354.
Liska A, Markowitz F, Bridges Whaley R and Bellair P (1999) Modeling the relationship between the criminal justice and mental health systems. *American Journal of Sociology* 104(6): 1744–1755.
McRuer R (2002) Compulsory able-bodiedness and queer/disabled existence. In: Snyder S et al. (eds) *Disability Studies: Enabling the Humanities.* New York, NY: MLA Press, 88–99.
McRuer R (2006) *Crip Theory: Cultural Signs of Queerness and Disability*. New York, NY: New York University Press.
Miller JG (1991) *Last One over the Wall: The Massachusetts Experiment in Closing Reform Schools*. Columbus, OH: Ohio State University Press.
Mills CW (1959) *The Sociological Imagination*. Oxford: Oxford University Press.
Morris J (2001) Impairment and disability: constructing an ethics of care that promotes human rights. *Hypatia* 16(4): 1–16.
Nibert D (1995) The political economy of developmental disability. *Critical Sociology* 21(1): 59–80.
Oliver M (1990) *The Politics of Disablement*. London: Macmillan.
Pager D (2009) *Marked: Race, Crime, and Finding Work in an Era of Mass Incarceration*. Chicago, IL: University of Chicago Press.
Penrose L (1939) Mental disease and crime: outline of a comparative study of European statistics. *British Journal of Medical Psychology* 18(1): 1–15.
Perlin M (2000) *The Hidden Prejudice: Mental Disability on Trial*. Washington, DC: American Psychological Association.
Petersilia J (2000) *Doing Justice? Criminal offenders with Developmental Disabilities*. CPRC Brief. California Policy Research Center, University of California.
Pew Center (2008) *One in 100: Behind Bars in America 2008.* Washington, DC: The Pew Charitable Trusts.
Prison Policy Initiative (2008) *Incarceration by Race and Mental Health Status*. Available (consulted 8 June 2010) at: http://www.prisonpolicy.org/research.html
Prouty RW, Smith G and Lakin KC (eds) (2005) *Residential Services for Persons with Developmental Disabilities: Status and Trends through 2004.* Minneapolis, MN: Institute on Community Integration, Research and Training Center on Community Living, University of Minnesota.
Puar J (2009) Prognosis time: towards a geopolitics of affect, debility and capacity. *Women and Performance: A Journal of Feminist Theory* 19(2): 161–172.
Rafter NH (1997) *Creating Born Criminals*. Urbana, IL: University of Illinois Press.
Rafter NH (2004) The criminalization of mental retardation. In: Noll S and Trent J (eds) *Mental Retardation in America: A Historical Reader*. New York, NY: New York University Press, 232–257.
Reaume G (2000) *Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870–1940.* Toronto: Oxford University Press.
Rothman DJ (1971) *The Discovery of the Asylum; Social Order and Disorder in the New Republic*. Boston, MA: Little Brown.
Russell M (1998) *Beyond Ramps: Disability at the End of the Social Contract – A Warning from an Uppity Crip.* Monroe, ME: Common Courage Press.
Russell M (2001) The new reserve army of labor? *Review of Radical Political Economics* 33(2): 224–234.

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Russell M and Stewart J (2001) Disablement, Prisonand Historical Segregation. MonthlyReview, 53(3) July- August

Russell M and Stewart J (2001) *Disablement, Prison and Historical Segregation*. *Monthly Review* 53(3). Available (consulted 23 November 2011) at: http://monthlyreview.org/2001/07/01/disablement-prison-and-historical-segregation

Scull AT (1979) *Museums of Madness: The Social Organization of Insanity in Nineteenth Century England*. London: Allen Lane.

Scull AT (1989) *Social Order/Mental Disorder: Anglo-American Psychiatry in Historical Perspective*. Berkeley, CA: University of California Press.

Sim J (2009) *Punishment and Prisons: Power and the Carceral State*. Los Angeles, CA: Sage.

Snyder S and Mitchell DT (2006) *Cultural Locations of Disability*. Chicago, IL and London: University of Chicago Press.

Steadman H, Monahan J, Duffee B, et al. (1984) The impact of state mental hospital deinstitutionalization on United States prison populations, 1968–1978. *Journal of Crime, Law and Criminology* 75(2): 474–490.

Stone D (1994) *The Disabled State*. Philadelphia, PA: Temple University Press.

Thomson RG (1997) *Extraordinary Bodies: Figuring Physical Disability in American Culture and Literature*. New York, NY: Columbia University Press.

Thomson RG (2000) Seeing the disabled: visual rhetorics of popular disability photography. In: Longmore P and Umansky L (eds) *The New Disability History: American Perspectives*. Ithaca, NY: New York University Press, 335–374.

Thomson RG (2002) Integrating disability, transforming feminist theory. *NWSA Journal* 14(3): 1–31.

Thomson RG (2009) *Staring: How We Look*. Oxford: Oxford University Press.

Torrey EF (1996) Out of the Shadows: *Confronting America's Mental Illness Crisis*. John Wiley.

Tremain S (2002) On the subject of impairment. In: Corker M and Shakespeare T (eds) *Disability/Postmodernity: Embodying Disability Theory.* London: Continuum, 32–47.

Trent JW (1995) *Inventing the Feeble Mind: A History of Mental Retardation in the United States*. Berkeley, CA: University of California Press.

Veneziano L and Veneziano C (1996) Disabled inmates. In: McShane M and Williams F (eds) *Encyclopedia of American Prisons*. New York, NY: Garland Publishing, 157–161.

Wacquant L (2009) *Punishing the Poor*. Durham, NC: Duke University Press.

Wendell S (1996) *The Rejected Body: Feminist Philosophical Reflections on Disability*. London: Routledge.

Western B (2006) *Punishment and Inequality in America*. New York: Russell Sage Foundation.

Wolfensberger W (1989) Human service policies: the rhetoric versus the reality. In: Barton L (ed.) *Disability and Dependency*. Lewes: Falmer Press, 23–41.

Zola IK (1991) The medicalization of aging and disability. *Advances in Medical Sociology* 2: 299–315.

Downloaded from crs.sagepub.com at Univ of Illinois at Chicago Library on December 30, 2011